

# REGISTRATION FORM

Michael A. Scannon M.D. | Thomas M. Taylor M.D. | George L. Bondar, D.O. | Sandy Snyder, P.A.-C

Please Fill Out as Completely and Accurately as Possible. This is a very important part of your MEDICAL RECORD. PLEASE PRINT.

Patient's Last Name \_\_\_\_\_ Patient's First Name \_\_\_\_\_ MI \_\_\_\_  
Sex \_\_\_\_\_ Marital Status \_\_\_\_\_  
Street Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Home Phone \_\_\_\_\_ Birth Date \_\_\_\_\_ Social Security # \_\_\_\_\_  
Primary Care Physician \_\_\_\_\_  
Employer \_\_\_\_\_ Occupation \_\_\_\_\_  
Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Please check if you are one of the following:  nurse  veteran  teacher

Please list the family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis: \_\_\_\_\_  
\_\_\_\_\_

## INSURANCE / GUARANTOR INFORMATION

Self  Insured  Guarantor (Check The Box That Applies, If Self Skip To Insurance Company Name)

Insured's / Guarantor's Last Name \_\_\_\_\_  
Insured / Gurantor's First Name \_\_\_\_\_ MI \_\_\_\_ Relationship \_\_\_\_\_  
Street Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Home Phone \_\_\_\_\_ Birth Date \_\_\_\_\_ Social Security # \_\_\_\_\_

Primary / First Insurance Company \_\_\_\_\_  
Supplemental / Second Insurance Company \_\_\_\_\_

## Authorization

I Hereby Authorize Michael A. Scannon, M.D. Or Thomas M. Taylor, M.D. To Render Treatment To Me

I Hereby Authorize Payment of Medical Benefits To Michael A. Scannon, M.D. Or Thomas M. Taylor, M.D.

I Hereby Agree To Pay Any Fee Incurred In The Course Of My Treatment, As Such Services Are Rendered, To Michael A. Scannon, M.D. Or Thomas M. Taylor, M.D.

I Hereby Authorize Any Physician, Or Hospital To Release Records To Michael A. Scannon, M.D. Or Thomas M. Taylor, M.D.

I Hereby Authorize Michael A. Scannon, M.D. Or Thomas M. Taylor, M.D. To Release Medical Records To Any Physician, Or Hospital Upon Written Request For Such Information.

Signature of Patient, Parent, Or Guardian X \_\_\_\_\_ Date \_\_\_\_\_

\*\*\*Please Fill Out Other Side\*\*\*

Important: Please fill out the following as COMPLETELY as possible. This is a very important part of your medical record. PLEASE PRINT.

### Emergency Contact:

Last Name \_\_\_\_\_ First Name \_\_\_\_\_  
Relationship \_\_\_\_\_ Home Phone \_\_\_\_\_  
Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

### CLINICAL INFORMATION

State briefly why you need to see this doctor: \_\_\_\_\_  
\_\_\_\_\_

Do you take any medications regularly? If Yes, please list: \_\_\_\_\_  
\_\_\_\_\_

Are You allergic to anything? (foods, plants, animals, drugs, etc.) \_\_\_\_\_  
If Yes, please list: \_\_\_\_\_  
\_\_\_\_\_

Do You now, or have you ever had any major medical problems? If yes, please explain:  
\_\_\_\_\_  
\_\_\_\_\_

Have you ever had surgery? For what and when? \_\_\_\_\_  
\_\_\_\_\_

Are there any major medical problems in your family? \_\_\_\_\_  
\_\_\_\_\_

Do you Smoke? If so how much and what you do smoke (eg. cigarettes...pipe...cigars)?  
\_\_\_\_\_  
\_\_\_\_\_

Do you Drink? If so how much?  
\_\_\_\_\_  
\_\_\_\_\_

Have You ever had any of the following? If Yes, please check. \_\_\_\_\_  
 Eczema  Heart Disease  Kidney Disease  Gastric Problems  Asthma  Hives  
 Ulcers  Tuberculosis  Hayfever  Psoriasis  High Blood Pressure  
 Other: \_\_\_\_\_  
 Hepatitis  Diabetes  Bleeding Problems  Other: \_\_\_\_\_